REVISED TBS PROCEDURES
CONTRACT PROVIDERS
PROVISIONAL

1. A referral is sent by County TBS to the contractor who opens the case in the MIS system (INSYST). A case manager is assigned and the assigned case manager contacts family to set up an assessment meeting. Contractor shall contact family within five business days after receiving referral packet from County TBS facilitator. The family shall be contacted within three days if an Expedited referral (urgent) is received. This meeting should take place as soon as possible within the week of referral receipt.

2. The Assessment Meeting

- Consists of the case manager and family and client. If the client lives in a group home or residential treatment center then the assessment meeting shall consist of the client, specialty mental health provider (SMHP), case manager, and a line staff person. The case manager shall explain the TBS process again and answer any questions team members might have.
- The client/family is informed of their rights.
- The case manager will complete the initial TBS assessment (pending additional information with the Specialty Mental Health Provider if this has not yet been obtained), set goals with input from the client/family and develop a provisional TBS Treatment Plan, to include target behaviors and goals and objectives.

3. The TBS treatment plan is written as soon as possible. Specialty Mental Health Provider (SMHP) information is gathered over the phone. If the case managers are unable to reach the SMHP, they may write a generic statement: "SMHP will address the clinical issues associated with (e.g., *noncompliant and aggressive)* behavior." Input from the Specialty Mental Health Provider shall occur no later than the time of the second meeting which is called the implementation meeting.

4. Coach may start when a tentative treatment plan is in place. The coach start date should be as soon as possible after the assessment and plan are completed.

5. The implementation meeting is held as soon as possible after the assessment meeting. It must be convened within two weeks. All team members (client, caregiver, SMHP, coach, case manager, facilitator) attend the implementation meeting, and the treatment plan is reviewed, revised, and signed. The implementation meeting can be scheduled at any time. Example:

- during the call to the SMHP,
- during the call to set up the assessment meeting (if a coach is readily available to start),
- during the assessment meeting,
- when the coach start date is determined.

Contractor shall present an initial TBS treatment plan and a crisis prevention plan at the implementation meeting. The TBS treatment plan shall reflect the target behaviors from the initial TBS assessment and are consistent with the SMHP client service plan. TBS services shall be incorporated as part of the SMHP service plan.

6. Contractor shall begin coaching services within 30 days of receipt of the TBS referral from the TBS facilitator.
7. Contractor shall convene twice monthly treatment team meetings with the client, caregivers, SMHP, TBS case manager, TBS coaches, and county TBS facilitator to review progress towards goals.
8. Contractor shall send to the County TBS facilitator, within 5 days of the monthly treatment review meeting, a copy of the TBS updated treatment plan which includes progress toward goals, any changes to coaching hours and time, date, and location of next treatment review meeting.
9. Contractor in consultation with the client/family and the TBS facilitator shall continuously assess case progress or lack of to determine if client is benefiting from TBS. A titration schedule and stabilization period of 1-2 weeks shall be implemented as TBS case progresses positively.
10. Contractor shall consult with client/family, TBS facilitators and the treatment team when a case is not progressing to determine whether the TBS plan requires modification or whether TBS services should be discontinued and/or another resource should be considered. Contractor shall assist client and caregiver with appropriate resources.
11. Contractor shall provide a discharge summary to the county TBS facilitator within two weeks of the last TBS coaching service.

COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES
CHILDREN'S MENTAL HEALTH SERVICES
TBS GUIDELINES

Policy 1
Regional Center Referrals
All Regional Center Client referrals shall be evaluated to determine whether the client meets Medical Necessity, including diagnosis, intervention and impairment criteria; and whether the client can benefit from behavioral intervention. The Initial TBS Assessment conducted by the contract provider may be utilized as part of the eligibility determination process.

Policy 2
Assessment Requirements
County TBS staff will review all TBS referrals (per DMH Letter 02-08) to determine eligibility. All regular referrals shall be approved, denied, or withdrawn within a fourteen (14) calendar day period (per DMH Letter 04-03). Referrals made with a Request for Expedited Review must be decided upon within 3 business days, unless necessary information is not provided, in which case the review process may be extended for an additional 14 calendar days. The facilitator will follow DMH guidelines for extending the review period.
The contractor will complete an Initial TBS Assessment at the assessment meeting. If this assessment reveals that the client is not eligible for TBS, the contractor shall contact the facilitator to review criteria, and if sustained, the County will issue the NOA-B.

Policy 3
Initial and Implementation Meeting Requirements
If approved, County TBS shall forward (via fax) a complete referral packet to one of the two TBS providers. The TBS provider will contact family members/care providers upon opening the case to schedule an assessment meeting in the home or other place of residence. If there is a delay in scheduling the Initial meeting, the provider shall communicate with County TBS (via phone or fax).
At the assessment meeting the contract case manager will conduct the initial TBS assessment and have the family sign necessary documentation. The case manager shall determine days and hours of service, target bxs, and all that is necessary to create the TBS treatment plan. The case manager will write the treatment plan as soon as possible, provide a copy to the assigned coach(es), and start service. The case manager will contact all involved parties to schedule the implementation meeting as soon as possible after the coach start date. The implementation meeting shall not take place more than two weeks after the assessment meeting. At the implementation meeting, the contractor shall have all members of the TBS team sign the TBS treatment plan. The contractor shall provide members of the team with a copy of the TBS treatment plan.

The TBS provider must inform County TBS staff if meetings cannot be held within designated timeframe. Bi-weekly meetings shall occur following the implementation meeting. A treatment plan review meeting is due within 30 days of the implementation meeting and monthly thereafter. If a review meeting must be rescheduled, every effort must be made to schedule within the week. The Specialty Mental Health Provider should be the active clinical lead during the meetings. The parent and child should be actively involved. All participants should be prepared for the meeting. Documentation and hard information, not anecdotal, is needed at each review meeting; bring all necessary material.

Policy 4
Monthly Review Meetings
Monthly Review meetings will be attended by the Core Team, which includes parent/primary caregiver, client, Specialty Mental Health Provider, TBS Coach, County TBS staff and TBS case manager. Invitations to review meetings may include but are not limited to DSS, Probation, WRAP team, CPS Dependency Worker, Case Managers, and Conservator.

Policy 5
Contact and Communication
The County staff and TBS provider shall discuss meeting issues and concerns prior to each meeting to ensure that the facilitator and case manager have established a consistent and clear plan of action. Communication between the Case Manager and SMHP shall occur as needed to provide treatment consistency.

Policy 6
Start Date
The day the TBS Coach starts to provide direct one-to-one services is the "actual start date" of TBS. The start date of TBS services shall be documented on the provider's weekly population update and forwarded to the County TBS coordinator. The coach start date is the "Beginning Date of Therapeutic Behavioral Services" on the DMH Notification.

Policy 7
Parent/Caregiver Participation
Clients who are under age 18 must have a parent/caregiver present whenever a TBS Coach is providing direct one-to-one service. Clients who are between the age of 18 and 21 may receive TBS without parental/caregiver participation. Efforts will be made to engage the parent/caregiver in supporting the young adult when appropriate.

Policy 8
Absences
If a youth or parent is unexpectedly absent from a review meeting, the meeting can be held; however, the missing person(s) shall receive a summary of the events of the meeting by the TBS provider. The TBS provider will monitor any absence(s) and consult

with County TBS staff regarding a plan of action. A pattern of absences by the parent/child/young adult may result in termination of services.

Policy 9
Weekly Updates to County TBS Unit
TBS provider shall submit a weekly "Population Update", which includes the following information for each child/youth/young adult receiving TBS:

A. Name
B. Hours per week of TBS
C. Cumulative hours of TBS
D. Weekly schedule of TBS (e.g., Monday – Friday 4 a.m. – 7 a.m.)
E. Location of TBS services (home, group home, Polinsky)
F. Service Start Date
G. Total Open TBS cases

All reports shall be faxed to the County TBS Program Manager or designee by Monday of every week.

Policy 10
Unusual Occurrence Reporting
County TBS and the TBS providers shall follow the policy and procedures for "Unusual Occurrence Reporting".

Policy 11
CPS/APS Reporting
If there is a discrepancy regarding whether to file a report based on an incident report, the coach or other TBS worker should call CPS/APS to obtain clarification as to whether a report is required in that situation.

Policy 12
Crisis Plans
The Core TBS team, including the TBS coach shall develop a crisis plan by the implementation meeting and utilize and update as appropriate.

Policy 13
Complaints Regarding TBS Provider Staff

a. The County TBS Program Manager will redirect any complaints or concerns back to the TBS provider supervisor.
b. The TBS provider will send a written Unusual Occurrences Report to the County TBS Program Manager or designee with the following information: nature of complaint, provider investigation, corrective action plan including feedback to other involved providers, agency staff or family members.
c. The TBS provider will give the family/parent a copy of the Grievance and Appeal Procedure and enter the complaint in the Suggestion/ Provider Transfer Request Log.

Policy 14
Release of Information/Consent

a. County TBS staff will obtain the most current release of information prior to sending the referral to the TBS provider.
b. The contract provider shall obtain a current release of information/consent from all individuals participating in the TBS planning process according to their policies.
c. In the event information must be released without a signed authorization, due to an urgent need to provide clinical services to the client, staff should document that the information was shared, obtain verbal consent and document consent in progress note.
d. When the client is nondependent minor or adult, County TBS will obtain the Consent for Treatment at the implementation meeting. When the client is a dependent, County TBS will obtain the Consent for Treatment – Court or – Parent prior to approving the referral.

Policy 15
Diagnosis

Prior to the approval of TBS, County TBS staff shall contact the specialty mental health provider to obtain the current working DSM-IV diagnosis. The team will insure that the behavioral goals and interventions are consistent with the primary diagnosis of treatment and with the overall specialty mental health service (treatment) plan. If there is a change in diagnosis during the term of service, all providers will communicate this change in order to insure consistency in treatment.

Policy 16
Medi-Cal Verification

County TBS shall verify Medi-cal eligibility upon receipt of referral. TBS providers shall verify Medi-Cal eligibility of all clients by the fifteenth of every month and communicate, in writing, to County TBS when client's Medical eligibility ceases. TBS shall be immediately suspended until Medi-Cal eligibility can be verified.

Policy 17
Out of County Referrals

For out of county referrals to TBS, the referring county must make their own arrangements with local TBS providers, per state direction. San Diego County may make their TBS providers available to other counties as resources permit.

Policy 18
Position Descriptions

County TBS staff = TBS Facilitator
Contractor TBS staff= Case Manager
One to one aide = Coach
Treating Therapist or Intensive Case manager = Specialty Mental Health Provider

Policy 19

Freedom of Choice
The client has freedom of choice. Client and caregiver shall be informed of freedom of choice and informed consent received prior to approval of services. The contractor shall take steps to ensure that the coach and client is a good match. The client has a right to request a different coach or a different contractor.

Policy 20
Coaches in Therapy
There shall be no TBS coaches in any individual or group therapy session or medication management meeting with the psychiatrist whether the client is in the community or in a residential facility.

Policy 21
Private Insurance
Contractors are not obligated to accept clients with Other Health Insurance as they will not be reimbursed for their services if a denial from the private insurance agency is not obtained. If the Contractor elects to accept clients with Other Health Insurance, both they and County must obtain a signed Assignment of Insurance Benefits form.

Policy 22
DMH Notification and Certification Letter
County TBS facilitators shall notify DMH of TBS service provision to each client. This form is submitted within 10 days of the coach start date (initial notification). County TBS will be responsible for forwarding Certification Forms to DMH.

Policy 23
Age requirement
TBS can be provided up to the client's twenty-first birthday.

Policy 24
Scheduled TBS shift
TBS Coaches shall wait fifteen minutes at the client's home for an authorized caregiver and/or child to be available for service. If the caregiver and/or child are not available for service following the fifteen-minute period, the Coach shall exit the service area and contact their direct supervisor.

Policy 25
Administrative Meeting Attendance
TBS Contractor shall participate in monthly Children's Mental Health Outpatient Program Manager meetings or similar adult mental health provider meetings. TBS Contractor shall participate in regular TBS provider meetings.

Policy 26
Provider Qualifications
TBS Contractor shall furnish, operate and maintain TBS in accordance with the most current:

A) TBS Implementation Plan, County of San Diego, Health and Human Services Agency, Child & Youth Mental Health System of Care.
B) San Diego County Child and Adolescent Medi-Cal Specialty Mental Health Services-Site Review.
C) DMH letter, No. 04-11, 04-03, 99-03.
D) State Short-Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management.
E) Children's Mental Health Outpatient Policy and Procedure Manual or Adult Mental Health equivalent.
F) DMH Information Notice No.: 05-09, 02-08, 00-03.
G) All subsequent and current related DMH Letters and Notices.

Policy 27

TBS Payment Authorization/Reauthorization

Effective September 1, 2003, County TBS shall be required to authorize payment of all TBS in advance of service delivery. The payment authorization must be done by a licensed practitioner of the healing arts (LPHA) as required by Title 9, CCR, Section 1830.215. Initial authorization must be based on eligibility information provided on the TBS referral form and, when possible, by contact with parent/caregiver and therapist. A complete TBS assessment and treatment plan must be done during the initial authorization period which will consist of 30 days. TBS must be reauthorized thereafter every 60 days. Reauthorization must be based upon specific documentation (refer to County of San Diego TBS Reauthorization Request form).

TBS Contractors shall be responsible for monitoring service days. TBS Contractors shall submit reauthorization requests (via the Request for Reauthorization form) prior to the deadline. County TBS shall approve or deny reauthorization request within three working days. When the contractor submits a request for a fourth payment authorization, the request must include information about client progress towards target goals, a summary of services provided, a titration plan with established benchmarks, and a planned date of termination.

When County TBS approves a fourth payment authorization, County TBS shall be required to provide a summary and justification of the TBS services provided, in writing to the Mental Health Director for the MHP of the beneficiary and to the DMH Deputy Director, Systems of Care, within five working days of the authorization decision. (Refer to DMH Letter 02-08.)

Policy 28

Clients' Access and Authorization for Interpreter Services

Interpreter services shall be available to clients with limited English proficiency (LEP) in threshold and non-threshold languages if it is determined to assist in the delivery of Therapeutic Behavioral Services. If the Contractor program cannot meet the need for language services then interpreter services shall be utilized. County approved providers are:

- Interpreters Unlimited (for language interpreting) @ (858) 451-7490

- Deaf Community Services (deaf and hearing-impaired) @ (800) 290-6098

Contractor should request a "qualified but not certified" interpreter and shall coordinate the meeting attendance. Prior approval shall be obtained for all meetings in which interpreting services are utilized. Contractor shall complete an HHSA Service Authorization Form for each meeting and fax it to County TBS Program Manager or designee for approval. County shall approve services within 2 business days and return form to contractor to forward to the interpreter service. When interpreting services are completed, the contractor shall complete Section B of the Authorization form and forward it to the interpreter service.

For ongoing interpreter service, i.e., when an interpreter is needed for coaching, the contractor shall fax County a separate HHSA Service Authorization Form and the TBS Authorization Form, which identifies the services provided on a biweekly basis. The HHSA Service Authorization Form should reference the TBS Authorization Form for specific dates and times of service.

Policy 29

Verification of SMHP Licensure/Registration Status

As part of the referral review process, it is the responsibility of the facilitator to verify the active status and qualifications of the SMHP. This verification can be achieved by accessing the website of the responsible licensing board, printing the license verification, and filing it in the client's medical record.

Policy 30

Client ineligibility.

If a referral is denied, the facilitator shall complete a Notice of Action (NOA-B) documenting the reason for the denial and notifying the beneficiary of his/her rights. The NOA is distributed according to County policy. If the client is ineligible because he/she is not full-scope Medi-Cal, the referral will be returned. If the initial TBS assessment reveals that the client is not eligible for TBS, the contractor shall contact the facilitator to review criteria, and if sustained, the County will issue the NOA-B.

Date: _____

THERAPEUTIC BEHAVIORAL SERVICES REFERRAL FORM

Client Name:_____ DOB:_____ Medi-Cal No.:_____

Current Address: _____

Parent/Caregiver:_____ Phone No :_____

Current therapist & Agency:_____

Phone:_____ Fax:_____

Referring Party & Agency:_____

Phone:_____Fax:_____

Agencies Involved: (circle if applicable) AB2726 CWS Probation Regional Center

Case Manager(s): Name _____Phone No._____

Name:_____Phone No. _____

I. Is child/youth full scope MediCal beneficiary under age 21? Yes No

II. Please list client's current Axis I diagnosis:_____

III. Which of the following conditions have been met? (circle all that apply)

1. At least one emergency psychiatric hospitalization related to current presenting disability within the past 24 months
2. Currently placed in a level 12 or above group home for mental health needs
3. Being considered for placement in a level 12 or above group home
4. Previously received Therapeutic Behavioral Service (TBS) through MediCal

and which is highly likely to occur, without additional support? (circle 1 or 2)

1. Child/youth may need higher level of residential care or acute care
2. Child/youth is transitioning to a lower level of care and needs TBS to support the transition.

IV. What are the specific problem behaviors jeopardizing current living situation?

_____

_____

_____

_____

V. Are there any specific needs with regard to the TBS coaches' language, culture or gender?

_____

_____

SIGNED RELEASE OF INFORMATION (23-07 HHSA or DSS 04-24 version 6/03 or 04/04) MUST ACCOMPANY REFERRAL.

Fax referral packet to Melinda Leal, Therapeutic Behavioral Services at (619) 401-4627 or mail to P.O. Box 85524, San Diego, CA 92186-5524

EXPEDITED REVIEW REQUEST
Mental Health Plan Payment Authorization
For Therapeutic Behavioral Services
Mental Health Plan Name: _____

Initial Authorization Request _____ Reauthorization Request _____

Provider Information	**Beneficiary Information**
Provider Name	Beneficiary Name
Provider Address	Beneficiary Medi-Cal Number
Provider Number_____ Phone Number _____	DOB _____

Provider Certification:

I certify under penalty of perjury that an expedited review of the accompanying MHP payment authorization request is necessary because the standard 14 day authorization timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

Signature of Provider _____ Date _____

Examples of Reasons for an Expedited Request

Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.

The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

DATE:

PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:

TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:
AKA'S:		

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.		
LAST NAME OR ENTITY: **COUNTY OF SAN DIEGO** Children's Mental Health Services	FIRST NAME:	MIDDLE INITIAL:
ADDRESS: 1000 BROADWAY, SUITE 105	CITY/STATE: EL CAJON, CA	ZIP CODE: 92021
TELEPHONE NUMBER :(619) 401-4630 FAX (619) 401-4627	DATE:	

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.		
LAST NAME OR ENTITY: COUNTY OF SAN DIEGO, CONTRACTED PROVIDERS, OR OTHERS - **SEE PAGE 3 FOR LIST OF SERVICE/PROGRAMS**	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	DATE:	
TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory Results
- ☐ Dental Records
- ☒ Psychiatric Records
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy Records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing Records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

FOR OFFICE USE

VALIDATE IDENTIFICATION ☐

SIGNATURE OF STAFF PERSON:	DATE:

SIGNATURE OF MEDICAL DIRECTOR:	DATE:

COUNTY OF SAN DIEGO
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

THERAPEUTIC BEHAVIORAL SERVICES

By signing below, you are authorizing HHSA-TBS and its contract providers (New Alternatives, Inc., and Mental Health Systems, Inc.) to obtain and exchange information with all agencies so indicated on this page. (Provider List Updated 1-5-07)

___ **ALL PROVIDERS LISTED**

___ Aurora Behavioral Health
___ Bayview Behavioral Health
___ Behavioral Health Group
___ Casa De Amparo
___ Child, Youth & Family Network
___ Community Research Foundation
___ Episcopal Community Services
___ Family Health Center
___ Fred Finch Youth Center
___ Harmonium, Inc.
___ HHSA – CMHS
___ HHSA – AMHS
_X_ MediCal
_X_ Mental Health Systems Inc.
_X_ New Alternatives, Inc.
___ North County Lifeline
___ Palomar Pomerado Behavioral Health
___ Public Conservator Office
___ Rady Children's Hospital
___ Rady Children's Outpatient Psychiatry
___ San Diego Center for Children
___ SAY San Diego
___ SDYCS
___ South Bay Community Services
___ Sharp Mesa Vista
___ Telecare
___ Trinity Foster Care
___ UCSD-CAPS
___ UPAC
___ Vista Hill Foundation
___ Walden Environment
___ YMCA

___ Other: *Current Therapist (write name):*
___ Other:_____
___ Other:_____
___ Other:_____
___ Other:_____

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

INITIAL TBS ASSESSMENT

See TBS Referral Form for additional assessment information.

I. Identifying Information

Client Name: _____ Client #: _____ Assessor: _____

Information Source: _____ Relationship: _____ Date: _____

II. Identification of child/youth's specific behaviors/symptoms that jeopardize continued placement in a current facility or are expected to interfere when the child/youth is transitioning to a lower level of residential placement.

Circle each problem behavior that is putting placement/transition at risk and indicate how many times it typically occurs, e.g., 4X/week or 2X daily. Star (*) most serious bxs.

BEHAVIORAL AREA	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	OTHER	FREQ.
Physical aggression	Pushing		Spitting		Kicking Hitting		Escalation needing restraint			
Property destruction	Throwing objects		Breaking objects		Breaking furniture		Punching holes			
Self-harm behavior	Cutting on self		Suicidal gestures		Head banging or similar bx		Suicide attempts			
AWOL	Stays in sight		Returns same day		Gone overnight		Leaves for days			
Sexualized behavior	Inappropriate talk		Inappropriate gestures		Touches or grabs others		Assaults others			
Inapprop. Boundaries	Gets in others' space		Touches w/o permission		Hugs w/o permission		Gets into others things		Steals	
Verbal aggression	Rude/ disrespectful		Yells/swears, Threatens		Obscene or abusive language					
Noncompliant/Oppositional Bx	Argues excessively		Needs many prompts		Refuses to follow dir's		Escalates with direction			
Meds compliance	Needs prompts		Hides/cheeks meds		Refuses meds					
School compliance	Needs many prompts to go		Often misses school		Refuses to go					
Hygiene	Poor grooming		Resists bathing		Refuses to bathe					
Other										
Other										

III. If TBS is used, what changes are desired, so that placement/transition is no longer at imminent risk?

Complete the matrix again, showing a reduction in frequency of the problem behaviors or a change in intensity.

BEHAVIORAL AREA	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	SPECIFIC BX	FREQ.	OTHER	FREQ.
Physical aggression	Pushing		Spitting		Kicking Hitting		Escalation needing restraint			
Property destruction	Throwing objects		Breaking objects		Breaking furniture		Punching holes in the wall			
Self-harm behavior	Cutting on self		Suicidal gestures		Headbanging		Suicide attempts			
AWOL	Stays in sight		Returns same day		Gone overnight		Leaves for days			
Sexualized behavior	Inappropriate talk		Inappropriate gestures		Touches or grabs others		Assaults others			
Inapprop. Boundaries	Gets in others' space		Touches w/o permission		Hugs w/o permission		Gets into others' things		Steals	
Verbal aggression	Rude/ disrespectful		Yells/swears, Threatens		Obscene or abusive language					
Oppositionality	Argues excessively		Needs many prompts		Refuses to follow directions		Escalates with direction			
Meds compliance	Needs prompts		Hides/cheeks meds		Refuses meds					
School compliance	Needs many prompts to go		Often misses school		Refuses to go					
Hygiene	Poor grooming		Resists bathing		Refuses to bathe					
Other										
Other										

IV. Please list antecedents to the behaviors putting placement or transition at risk.

V. Days and Times that TBS may be requested, based on when problematic behaviors are occurring. This is an estimate.

Days: ___ Monday ___Tuesday ___Wednesday ___Thursday ___Friday ___Saturday ___Sunday ___Every day

___Unable to determine or days vary.

Hours: ___ Before school ___ All morning ___Noon ___After school ___Evenings ___ Till bedtime ___Other:

VI. Identification of Current Skills

What skills does the client currently utilize to manage behavior?

_____Able to soothe self (how?)_____
_____Able to express feelings associated with problematic bx.
_____Understands that behaviors lead to consequences
_____Is usually truthful
_____Able to take timeouts (independently or with prompting?)
_____Able to predict problematic behavior or situations
_____Accepts consequences
_____Shows remorse
_____Takes responsibility for behavior

Other skills/strengths:_____

_____

What interventions/consequences have been effective?_____

_____

VII. Other Services or Resources tried or considered. Note duration of services.

_____ Individual therapy _____Group therapy _____Family therapy _____ Day Tx _____ Residential Tx
_____Medication _____Hospitalization _____Wraparound/In-Home Support (name agency):_____
_____Regional Center _____SES _____TBS _____Other (specify):_____

What were the results of these services?_____
If lower level services were not used, why not? How is TBS justified? _____

_____

If TBS is not successful, what will result? _____

Assessor Signature/Credential:_____ Date:_____

Start Date:_____ **Monthly Review Date 1:** _____ **Review Date 2:** _____ **Review Date 3:**_____

CM Initials: _____ **CM Initials:** _____ **CM Initials:** _____

Specific Target Behavior #: _____: _____

Frequency/Duration/Intensity of Behavior: _____

Antecedents: _____

Goal/Desired Outcome: _____

Objective 1: _____

Anticipated Duration: _____ **Date Achieved:** _____

Objective 2: _____

Anticipated Duration: _____ **Date Achieved:** _____

Objective 3: _____

Anticipated Duration: _____ **Date Achieved:** _____

Interventions:

Client will: _____

Parent/Caregiver will: _____

Coach will: _____

Specialty Mental Health Provider (SMHP) will: _____

Support Staff will: _____

Client Strengths: _____

Transition Plan: _____

Outcome Goal (identify)	Achieved	Explanation (if No or N/A):
☐ Avoid psychiatric hospitalization	☐ Yes ☐ No ☐ N/A	
☐ Prevent higher level of care	☐ Yes ☐ No ☐ N/A	
☐ Move to lower level of care	☐ Yes ☐ No ☐ N/A	

Coach Start Date: _____

Anticipated Discharge Date: _____

TBS Hours Date:	Days and Times:	Total Hours:	Reason for Change

Signatures:

Client:_____ Date:_____ ☐ Client refused to sign, see progress note- Dated: _____

SMHP:_____ Date:_____ Parent/Guardian: _____ Date:_____

County TBS:_____ Date:_____ Staff/Caregiver:_____ Date:_____

TBS Case Manager: _____ Date:_____ HHSA/CWS:_____ Date:_____

TBS Coach:_____ Date:_____ Other: _____ Date:_____

☐ Client offered a copy of plan. Other: _____ Date:_____

Crisis Prevention Plan

Early warning signs that I may need assistance:

When I have any of these early warning signs I will:

Things I as the support person(s) can do to help:

Resources that we have available to us (including phone numbers):

- Therapist's phone number during work hours:
- Access and Crisis Line 1-800-479-3339

Resources at time of crisis (with phone numbers):

- Emergency Screening Unit (619) 421-6900

Emergency resources:

911

Client's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

Provider's Signature _____ Date _____

Date of Service:	HCPCS Code / InSyst Code:	Location of Service:
	H2019HE / (313)	1=Office 2=Field 3=Phone 4=Home 5=School 6=Satellite 7=Crisis Field 8=Jail 9=Inpatient
Staff ID:	Total Time HR: MIN:	Focus of Session: DSM-IV-TR Diagnosis Code(s): _____ ICD-9-CM Billing Code(s): _____

Client Appearance and any Risk Factors:

Target Behavior # 1:

Observation/Describe Behavior:

Intervention/Review of Tx Provided:

Result/Response:

Plan:

Target Behavior # 2:

Observation/Describe Behavior:

Intervention/Review of Tx Provided:

Result/Response:

Plan:

Continue on back

Target Behavior # 3:
Observation/Describe Behavior:
Intervention/Review of Tx Provided:
Result/Response:
Plan:
Target Behavior # 4:
Observation/Describe Behavior:
Intervention/Review of Tx Provided:
Result/Response:
Plan:
Comments/Other:
Print Name, Title:
Signature:
Date:

COUNTY OF SAN DIEGO
TBS REAUTHORIZATION REQUEST

TBS Contractor:_____ **Date Submitted:** _____
Client Name: _____ **Initial Authorization Start Date:** _____
Client Number: _____ **Coach Start Date:** _____
Authorization Period (*write start date of authorization period*): **Reauthorization Start Date:** _____

Authorization #2 _____ Authorization #3 _____ Authorization #4 _____

Please reference most recent TBS Treatment Plan and Progress Notes dated _____.

Specific Target Behavior # 1:

Objective:

Timeframe:
Progress towards goal: Yes No
If Yes, See Transition plan on page 2
If No, Alternatives Proposed and Justification for additional TBS hours:

Specific Target Behavior # 2:

Objective:

Timeframe:
Progress towards goal: Yes No
If Yes, See Transition plan on page 2
If No, Alternatives Proposed and Justification for additional TBS hours:

Specific Target Behavior # 3:

Objective:

Timeframe:
Progress towards goal: Yes No
If Yes, See Transition plan on page 2
If No, Alternatives Proposed and Justification for additional TBS hours:

Skills Parent/Caregiver is Learning:

Transition Plan:

Significant Changes in Child/Youth's Environment: Yes No
See Modified Treatment Plan dated: _____
If yes, check all that apply:
Move to a different residence _____
Entry/Exit of a significant family member _____
Illness/Death of significant family member/friend _____
Change in schools _____
Other _____ Explain:

Additional Comments:

Signature: _____ Date: _____
Completed by
Signature: _____ Date: _____
Licensed Clinician

Date Received by County TBS: _____

Reviewed by: _____
County TBS Facilitator

Reauthorization Period (circle one): Approved Denied

Explanation:

Signature: _____ Date: _____
County TBS Licensed Staff

County of San Diego
Health and Human Services Agency
Children's Mental Health Services

Client: _____
Medical Record No: _____
Program: _____

Date of Admission: _____ **Date of Discharge:** _____
Date of Transfer to Meds Only: _____

I. IDENTIFYING INFORMATION

Client's Age: _____ **DOB:** _____ **Client's Gender:** ☐Male ☐Female

Client's Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander: _____
☐ Caucasian ☐ American Indian ☐ Middle Eastern ☐Other: _____

II. CULTURAL ACCOMMODATIONS PROVIDED

☐Were not indicated
☐Utilized interpreter (on going or occasional) Language: _____
☐Bi Lingual provider (on going or occasional) Language: _____
☐Culturally specific referral recommendation: _____

Additional Comments: _____

III. PRINCIPAL DIAGNOSIS

DSM-IV-TR DIAGNOSIS	DIAGNOSTIC CODE
AXIS I	
AXIS I	
AXIS I	
AXIS II	
AXIS III Relevant Medical Conditions:	
AXIS IV Psychosocial and Environmental Problems:	
AXIS V **Current GAF:** **Highest GAF in Past Year:**	

☐**Yes** ☐**No** Client met additional Dual Diagnosis criteria of having a co-occurring substance use problem that does not meet the criteria for a substance-related diagnosis but causes significant impairment in the youth's life (this information to be captured in the Other Factor codes in InSyst).
☐**Yes** ☐**No** Client met additional Dual Diagnosis criteria of having a parent, caretaker, or significant other with a substance use problem. When familial substance use problem causes impairment in youth's life it may be noted on Axis IV above (this information to be coded in the "Other Factors" field in InSyst).

IV. REASON FOR ADMISSION

_____
_____
_____
_____
_____

V. STRENGTHS

Client: _____
Family: _____

VI. RISK ASSESSMENT HISTORY

☐Aggression ☐Fire Setting ☐Criminal Activity ☐Sexual Acting Out
☐Suicide Attempts ☐Runaway ☐Truancy ☐Explosive ☐School Dropout

Other pertinent risk issues when applicable (distinguish between past and present): _____
_____

VII. CASE SUMMARY

Client Plan goal(s) were met: ☐Yes ☐No ☐Partially

Treatment approaches and progress on Client Plan goals:

Reason for discharge:

☐Additional treatment not indicated at this time
☐Transfer to medication only
☐Failure to return to treatment
☐Discharge due to inconsistent attendance
☐Assessment completed. Client referred for treatment.
☐Other_____
(must include narrative)

Outline aftercare plan that includes client's living arrangements, school status, and any recommendations:

Referred to: _____ Appointment Date: _____ Time: _____

Substance abuse treatment recommendations: ☐Not Applicable ☐_____

VIII. DISCHARGE MEDICATION

Current Medication(s)	Current Dose	Frequency	Taken as Prescribed?
			☐Yes ☐No
			☐ Yes ☐No
			☐ Yes ☐No

☐Psychotropic medication is not indicated at this time
☐Referred to pediatrician for psychotropic medication: _____
☐Referred to the following provider/clinic for psychotropic medication follow up: _____
☐Client or caregiver declines referral for psychotropic medication.
☐Medical cautions / allergies: _____

Additional Information (when applicable): _____

IX. CURRENT FUNCTIONING (CFARS Rating) (past 2 months)

Use the following 1 to 9 scale to rate the child's current (within past 2 months) problem severity for each functional domain listed below. Place your rating number on the line to the right of the domain name. Also, using the list below each domain rating, place an "x" mark next to the adjectives or phrases that describe the child's symptoms or assets.

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression ____			**Anxiety** ____			
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt	
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds	
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive/Compulsive	☐Panic		
Hyper activity ____			**Thought Process** ____			
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations	
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination	
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact	
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds	
Cognitive Performance ____			**Medical / Physical** ____			
☐Poor Memory	☐Low Self-Awareness		☐Acute Illness	☐Hypochondria	☐Good Health	
☐Poor Attention/Concentration	☐Developmental Disability		☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care	
☐Insightful	☐Concrete Thinking		☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic	
☐Impaired Judgment	☐Slow Processing		☐Eating Disorder	☐Seizures	☐Stress-Related Illness	
Traumatic Stress ____			**Substance Use** ____			
☐Acute	☐Dreams/Nightmares		☐Alcohol	☐Drug(s)	☐Dependence	
☐Chronic	☐Detached		☐Abuse	☐Over Counter Drugs	☐Cravings/Urges	
☐Avoidance	☐Repression/Amnesia		☐DUI	☐Abstinent	☐I.V . Drugs	
☐Upsetting Memories	☐Hyper Vigilance		☐Recovery	☐Interfere w/Functioning	☐Med. Control	
Interpersonal Relationships ____			**Behavior in "Home" Setting** ____			
☐Problems w/Friends	☐Diff. Estab./ Maintain		☐Disregards Rules	☐Defies Authority		
☐Poor Social Skills	☐Age-Appropriate Group		☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver		
☐Adequate Social Skills	☐Supportive Relationships		☐Conflict w/Relative	☐Respectful		
☐Overly Shy			☐Responsible			
ADL Functioning ____			**Socio-Legal** ____			
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person	
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges	
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed	
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member	
Select: ☐ Work ☐School ____			**Danger to Self** ____			
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt	
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation	
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self	
☐Defies Authority	☐Not Employed	☐Suspended				
☐Disruptive	☐Terminated/ Expelled	☐Skips Class				
Danger to Others ____			**Security/ Management Needs** ____			
☐Violent Temper	☐Threatens Others		☐Home w/o Supervision	☐Suicide Watch		
☐Causes Serious Injury	☐Homicidal Ideation		☐Behavioral Contract	☐Locked Unit		
☐Use of Weapons	☐Homicidal Threats		☐Protection from Others	☐Seclusion		
☐Assaultive	☐Homicide Attempt		☐Home w/Supervision	☐Run/Escape Risk		
☐Cruelty to Animals	☐Accused of Sexual Assault		☐Restraint	☐Involuntary Exam/ Commitment		
☐Does not appear dangerous to Others	☐Physically Aggressive		☐Time-Out	☐PRN Medications		
			☐Monitored House Arrest	☐One-to-One Supervision		

Completed by: _____ _____

Print name Credentials

_____ _____

Signature Date

Co-Signature: _____ _____

(Required when completed by a Trainee) Date

Printed name, credentials, signature